Rhode Island Department of Health

Reportable Disease Confidential Case Report Form

For use by providers of clinical care

EPI-2002 FORM

If you need additional forms, access our web site at www.HEALTH.ri.gov

State of Rhode Island and Providence Plantations
Department of Health
3 Capitol Hill – Room 106
Providence, Rhode Island 02908-5097
Phone: (401) 222-2577 After hours reporting: 401) 272-5952
Fax: (401) 222-2477; (401) 222-2488

Name of Patient (Last) (First) (MI) Patient's Home Address (No. and Street)

(City or Town) State Zip code Birth date Age Patient's Telephone:

Select __ __/__ __/__ __ __ __ (__ __ __) __ __ __- __ __ __ __

Race ○ American Indian/Alaskan Native ○ Native Hawaiian/Other Pacific Islander ○ Asian ○ White ○ Black or African American ○ Unknown

Hispanic or Latino: ○ Yes ○ No ○ Unknown

Sex: ○ Male ○ Female ○ Unknown

Did patient die of this illness? ○ Yes ○ No ○ Unknown

Is patient a: (please check)

○ Health Care Worker ○ Student ○ Day Care Worker/ Day Care Attendee ○ Foodhandler

If yes, name and address of workplace, school or day care:

Name of disease: Clinical Onset Date Lab Diagnosis Date

_____ / / / /

Confirmatory laboratory data, immunization status (esp. for pneumococcal and meningococcal invasive disease), dates and comments (be specific):

Reporting provider's name and address:

Phone Number: (_____) _____

If hospitalized, date admitted: / /	Hospital (Name, City, State):	Patient Medical Record #

Additional comments:

(Please print)

Name of person completing report for provider:

Address: _____

Telephone: (_____) _____ Report Date: / /

Viral Hepatitis

IgM anti-HAV	○ Positive	○ Negative	○ Not Done
HBsAg	○ Positive	○ Negative	○ Not Done
IgM anti-HBc	○ Positive	○ Negative	○ Not Done
Chronic HbsAg carrier	○ Yes	○ No	○ Unknown
ELISA anti-HCV	○ Positive	○ Negative	○ Not Done
RIBA--HCV	○ Positive	○ Negative	○ Indeterminate

RT-PCR HCV _____ Genotype _____

Liver Function Tests: SGOT (AST): _____ SGPT (ALT): _____ Bilirubin: _____

Sexual preference ○ Heterosexual ○ Homosexual ○ Bisexual ○ Unknown

History of IV drug use ○ Yes ○ No ○ Unknown

Pregnancy status ○ Yes- Patient is pregnant ○ Sexual partner is pregnant ○ Unknown

Lyme Disease

ERYTHEMA MIGRANS:

Physician diagnosed EM 5 cm (2 in)? ○ Yes ○ No ○ Unknown

RHEUMATOLOGIC

Arthritis (objective joint swelling) ○ Yes ○ No ○ Unknown

NEUROLOGIC

Bell's palsy or other cranial neuritis? ○ Yes ○ No ○ Unknown

Radiculoneuropathy? ○ Yes ○ No ○ Unknown

Lymphocytic meningitis? ○ Yes ○ No ○ Unknown

Encephalitis/Encephalomyelitis? ○ Yes ○ No ○ Unknown

Antibody to *B. burgdorferi* higher in CSF than serum? ○ Yes ○ No ○ Unknown

CARDIOLOGIC

2nd or 3rd degree AV block? ○ Yes ○ No ○ Unknown

OTHER HISTORY

Name of antibiotic used this episode?

LYME VACCINE

Was patient vaccinated? ○ Yes ○ No ○ Unknown

If yes, specify number of doses: _____

Indicate date(s) vaccinated: ___/___/___ ___/___/___ ___/___/___

LYME DISEASE LABORATORY REPORT

Elisa (EIA)	○ Positive	○ Negative	○ Equivocal	○ Not Done
IFA	○ Positive	○ Negative	○ Equivocal	○ Not Done
Western Blot	○ Positive	○ Negative	○ Equivocal	○ Not Done